CUMULUS HOSPITAL
123 Neon Way, Las Vegas, NV 89101

Insurance Claim Form

I. PATIENT INFORMATION

Full Name: _____ Date of Birth (MM/DD/YYYY): _____Gender:_____Address:_____ _____City:_____ State:_____Zip Code:_____Phone Number:_____ Email: _____

II. INSURANCE INFORMATION

Insurance Provider: _____ Policy Holder Name: _____
Policy ID/Number: _____ Group Number: _____

III. CLAIM DETAILS

Please provide information regarding the service for which you are filing a claim.

Date of Service (MM/DD/YYYY): _____ Facility/Provider Name: _____Service/Procedure Performed: _____ Total Amount Charged: $_____ Reason for Claim: _____

IV. PATIENT CERTIFICATION & AUTHORIZATION

I certify that the information provided is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. I understand that I am responsible for any charges not covered by my insurance provider.

Patient/Guardian Signature: _____ Date: _____

V. OFFICE USE ONLY

Claim Received Date: _____Processed by: _____
Status: [ ] Approved [ ] Denied [ ] Pending Claim Reference #: _____